## 2023 SEBB Continuation Coverage (COBRA) Election/Change



We must receive this form **no later than 60 days** from the date your SEBB health plan coverage ends or from the postmark date on the SEBB Continuation Coverage Election Notice sent to you, whichever is later.

Your first premium payment and applicable premium surcharges are due to the Health Care Authority (HCA) no later than 45 days after your 60-day election period ends. We will not enroll you until we receive your first payment. If HCA does not receive your first payment during this 45-day timeframe, you will not be enrolled and you will lose your rights for SEBB Continuation Coverage (COBRA). Premiums and applicable premium surcharges are due from the date your other coverage ended.

This form replaces all SEBB Continuation Coverage (COBRA) Election/Change forms previously submitted. Therefore, you must complete the entire form, including the dependent section for any children you want to continue to cover.

Inaccurate, incomplete, or illegible information may delay coverage. Type or print clearly in black ink and use all capital, block lettering in the spaces provided. Example: JOHN

All forms and documents are available at hca.wa.gov/sebb-continuation under Forms & publications, or by calling the SEBB Program at 1-800-200-1004 (TRS: 711).



Remember to read and sign Section 7. To add or remove children, complete Section 8 on page 13.

## School employee information only

Last name

First name

Social Security number

Date SEBB health plan coverage ended

1	Subscriber			
Social Security number	Date of birth	Sex assigned a	at birth¹	
Last name		Male Gender identit	Female Cy <sup>2</sup>	
First name		Male Middle initial	Female Suffix	Χ
Phone number	Alternate phone number			

This field is required for health care services.

Gender X means a gender that is not exclusively male or female. This field is optional and will be kept private to the extent allowable by law. To learn more, visit HCA's website at hca.wa.gov/gender-x